UNITED STATES BANKRUPTCY COURT
EASTERN DISTRICT OF MICHIGAN
SOUTHERN DIVISION

In re:

City of Detroit, Michigan,

Debtor.

_____/

Bankruptcy Case No. 13-53846
Honorable Thomas J. Tucker
Chapter 9

EXHIBIT D (BLUE CROSS PLAN) IN SUPPORT OF DPLSA'S RESPONSE IN OPPOSITION TO CITY OF DETROIT'S MOTION FOR (I) DETERMINATION THAT THE DETROIT POLICE LIEUTENANTS AND SERGEANTS ASSOCIATION HAS VIOLATED THE TERMS OF THE CITY OF DETROIT'S CONFIRMED PLAN OF ADJUSTMENT AND THE ORDER CONFIRMING IT; AND (II) ORDER (A) ENJOINING FURTHER VIOLATIONS AND (B) REQUIRING DISMISSAL OF STATE ACTIONS [DOCKET NO. 9656]

PART 3 OF 14

Section 3: What BCBSM Pays For

This section describes the services we pay for and the extent to which they are covered.

- The services listed in this section are covered when services are provided in accordance with certificate requirements and, when required, are preauthorized or approved by BCBSM; however emergency services do not need to be preauthorized.

- Services provided in accordance with the terms of this certificate are covered services only when they are medically necessary (see the definition in Section 7), including BCBSM-approved noncontractual services that may be described in your treatment plan for case management. Some exceptions include voluntary sterilization, screening mammography, preventive care services, or contraceptive services.

  

  Medically necessary services that can be provided safely in an outpatient or office location are not payable when provided in an inpatient setting.

- We pay our approved amount (see the definition in Section 7) for the services you receive that are covered in this certificate and also may be covered in any **riders** you may have in addition to your certificate. Riders make changes to your certificate and are an important part of your coverage.

You are responsible for copayments, coinsurance and/or deductible for many of the benefits listed. For what you may be required to pay, see Section 2: "What You Must Pay."

We pay for services received from:

- Hospitals and other facilities

  Except for emergency room care, covered services performed in or by facilities must be prescribed by the attending physician and provided during an inpatient hospital stay or in the outpatient department of a hospital or other approved facility.

  

  If you or anyone covered under your contract receives medically necessary services from a hospital-based physician who does not participate with BCBSM, we pay our approved amount but you may be required to pay the balance. See "Nonparticipating Physicians and Other Providers" in Section 4.

- Physicians and other professional providers

  Covered services must be provided by persons who are legally qualified or licensed to provide them.

Allergy Testing and Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For other diagnostic services, see Page 30.

Locations: We pay for allergy testing and allergy therapy in a hospital (inpatient or outpatient), ambulatory surgery facility or a physician's office subject to the conditions described below.

We pay for:

- The following allergy testing and therapy services, performed by or under the supervision of a physician.
- Allergy Testing
  - Survey, including history, physical exam, and diagnostic laboratory studies
  - Intradermal, scratch and puncture tests
  - Patch and photo tests
  - Double-blind food challenge test and bronchial challenge test
- Allergy Therapy
  - Allergy immunotherapy by injection (allergy shots)
  - Injections of antiallergen, antihistamine, bronchodilator or antispasmodic agents

We do not pay for:

- Fungal or bacterial skin tests (such as those given for tuberculosis or diphtheria)
- Self-administered, over-the-counter drugs
- Psychological testing, evaluation or therapy for allergies
- Environmental studies, evaluation or control

Ambulance Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For emergency treatment services, see Page 36.

We pay for:

Ambulance services to transport a patient up to 25 miles. We will pay for a greater distance if the destination is the nearest medical facility capable of treating the patient's condition.

In any case the following conditions must be met:

- The service must be medically necessary because transport by any other means would endanger the patient's health.
- The fee must be only for the transportation of the patient, and does not include additional services that may be provided by physicians or other professionals and billed as ambulance services.
- The service must be to transport the patient to a hospital or to transfer the patient from a hospital to another treatment location such as another hospital, skilled nursing facility, medical clinic or the patient's home.

When ambulance service is used only to **transfer** the patient, the attending physician must prescribe the transfer.

- The service must be provided in a vehicle qualified as an ambulance and that is part of a licensed ambulance operation.

We pay for ambulance services when the ambulance has responded and the patient is stabilized and transport is not necessary or is refused, and in instances where the ambulance company arrives but the person that needed treatment has expired.

Air Ambulance

When transportation by air ambulance is required, the following conditions must be met:

- The use of an air ambulance is medically necessary and ordered by the attending physician
- No other means of transport is available, or the patient's condition requires transport by air rather than ground ambulance
- The patient is transported to the nearest facility capable of treating the patient's condition and
- The provider is licensed as an air ambulance service and is not a commercial airline

We do not pay for:

Services provided by fire departments, rescue squads or other emergency transport providers whose fees are in the form of a voluntary donation.

Anesthesiology Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for anesthesiology services in a hospital (inpatient or outpatient), a participating ambulatory surgery facility, or a physician's office subject to the conditions described below.

We pay for:

- Anesthesiology during surgery

  Services for giving anesthetics to patients undergoing covered surgery are payable to either:

  – A physician other than the operating physician

  

  If the operating physician gives the anesthetics, the service is included in our payment for the surgery.

  – A physician who orders and supervises anesthesiology services
  – A certified registered nurse anesthetist (CRNA) in an

    - Inpatient hospital setting
    - Outpatient hospital setting
    - Participating ambulatory surgery facility
    - Physician's office

    CRNA services must be performed under the medical direction of a licensed physician or under the general supervision of a licensed physician responsible for anesthesiology services.

  

  Anesthesiology services performed by a qualified employee of a hospital or facility are payable to the hospital or facility.

- Anesthesia during infusion therapy

  We pay for local anesthetics administered only when needed as part of infusion therapy done in a physician's office.

- Other Services

  We pay for covered anesthesiology services performed by a CRNA in a physician's office.

  Anesthesia services may also be covered as part of electroshock therapy (see Page 49) and for covered dental services (see Page 28).

Audiologist Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for audiologist services performed by an audiologist in a physician's office or other approved outpatient location.

We pay for:

- Services performed by an audiologist who when they are prescribed by a provider who is legally authorized to prescribe the services.

Cardiac Rehabilitation

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for cardiac rehabilitation in a participating hospital (inpatient or outpatient), or a clinic subject to the conditions described below.

We pay for:

- Cardiac rehabilitation services begun during a hospital admission for an invasive cardiovascular procedure (e.g., heart surgery) or an acute cardiovascular event (e.g., heart attack)

- Cardiac rehabilitation services given when intensive monitoring (i.e., through the use of EKGs) and/or supervision during exercise is required. Services may be given in:

  - An outpatient hospital setting
  - A physician-directed clinic (one in which a physician is on-site)

We do not pay for:

- Cardiac rehabilitation services that require less than intensive monitoring (EKGs) or supervision because the patient's endurance while exercising and management of risk factors are stable

Chemotherapy

For high dose chemotherapy used in bone marrow transplants, see Pages 103 – 106.

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

We pay for chemotherapeutic drugs. Since specialty pharmaceuticals may be used in chemotherapy treatment, please see the preauthorization requirement for Chemotherapy Specialty Pharmaceuticals described on Page 70.

To be payable, the drugs must be:

- Ordered by a physician for the treatment of a specific type of malignant disease
- Provided as part of a chemotherapy program and
- Approved by the Federal Food and Drug Administration (FDA) for use in chemotherapy treatment

If the FDA has not approved the drug for the specific disease being treated, BCBSM's Medical Policy department determines the appropriateness of the drug for that disease by using the following criteria:

- Current medical literature must confirm that the drug is effective for the disease being treated
- Recognized oncology organizations must generally accept the drug as treatment for the specific disease
- The physician must obtain informed consent from the patient for the treatment.

We also pay for:

- Physician services for the administration of the chemotherapy drug, **except** those taken orally
- The chemotherapy drug administered in a medically approved manner
- Other FDA-approved drugs classified as:
  - Anti-emetic drugs used to combat the toxic effects of chemotherapeutic drugs
  - Drugs used to enhance chemotherapeutic drugs
  - Drugs to prevent or treat the side effects of chemotherapy treatment
- Infusion pumps used for the administration of chemotherapy, administration sets, refills and maintenance of implantable or portable pumps and ports

Infusion pumps used for the administration of chemotherapy are considered durable medical equipment and are subject to the durable medical equipment guidelines described on Pages 34 to 35.

Chiropractic Services and Osteopathic Manipulative Therapy

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

Locations: We pay for chiropractic services and osteopathic manipulative therapy in a physician's office subject to the conditions described below.

For chiropractic services performed in conjunction with physical therapy, see Page 66.

We pay for:

- Osteopathic manipulative therapy on any location of the body and chiropractic spinal manipulation to treat misaligned or displaced vertebrae of the spine, with a combined maximum of 24 visits (in-network and out-of-network providers combined) per member per calendar year.
- Chiropractic office visits:
  - For new patients, we pay for one office visit every 36 months. A new patient is one who has not received chiropractic services within 36 months.
  - For established patients, we pay for one office visit per year. An established patient is one who has received chiropractic services within 36 months.
- Mechanical traction once per day when it is performed with chiropractic spinal manipulation. Visits for mechanical traction are applied toward your 60-visit benefit limit for physical, speech and language pathology, and occupational therapy services.
- Radiological services when X-rays are medically necessary to treat the spinal misalignment.

Clinical Trials (Routine Patient Costs)

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For oncology clinical trial services, see Page 57.

We cover the routine costs of items and services related to Phase I, II, III or IV clinical trials whose purpose is to prevent, detect or treat cancer or other life-threatening disease or condition. The member receiving the items or services must be a qualified individual, as defined in this certificate

Benefits are not limited or precluded for antineoplastic drugs when Michigan law requires that these drugs, and the reasonable cost of their administration, be covered.

Benefits are subject to the conditions described below.

We pay for:

- All routine services covered under this certificate and related riders that would be covered even if the member were not enrolled in an approved clinical trial

See definitions of approved clinical trial, life-threatening disease, routine patent costs, and qualified individual Section 7.

We do not pay for:

- The experimental or investigational item, device or service itself
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the trial participant, or
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more BCBSM-contracted (participating or in-network) providers participate in an approved clinical trial, BCBSM may require members to participate in the trial through one of those providers unless the trial is conducted outside of Michigan.

Contraceptive Services

See Page 14 in Section 2 for what you may be required to pay for these services.

We pay for contraceptive services for women as part of your preventive care benefit. Please see the preventive care benefit description of contraceptive services on Page 75 for more details.

Dental Services

See Section 2 beginning on Page 8 for what you may be required to pay for these services.

For dental surgery, see Page 94.

Locations: We pay for emergency dental care given in a hospital, ambulatory surgery facility or to treat accidental injuries when treatment is given in a dentist's office. We pay for other dental services in a participating hospital or a provider's office subject to the conditions described below.

We pay for:

- Emergency Dental Care

  Emergency dental care to treat accidental injuries within 24 hours of the injury to relieve pain and discomfort. We also pay for follow-up treatment completed within six months of the injury.

  

  A dental accidental injury occurs when an external force to the lower half of the face or jaw damages or breaks sound natural teeth, periodontal structures (gums) or bone.

- Dental Services in a Hospital

  - Treatment when a hospitalized patient has a dental condition that is adversely affecting a medical condition and treatment of the dental condition is expected to improve the medical condition.
  - Facility and anesthesia services may be payable if a hospitalized patient has a medical condition that makes it unsafe for dental treatment to be performed in the office setting.

  

  In these cases we pay for facility and anesthesia services to the hospital or facility **only**, not for the services of a dentist or other dental professional.

- Examples of such medical conditions are:

  - Bleeding or clotting abnormalities
  - Unstable angina
  - Severe respiratory disease
  - Known reaction to analgesics, anesthetics, etc.

  Medical records must verify the patient's adverse medical or dental condition which would require the above services.

  Procedures that are payable in the circumstances explained above include:

  - Alveoplasty
  - Diagnostic X-rays
  - Multiple extractions or removal of unerupted teeth

Dental Services (continued)

We pay for: (continued)

- Other Dental Services
  - Services to treat temporomandibular joint dysfunction (TMJ) limited to those described below:
    - Surgery directly to the temporomandibular joint (jaw joint) and related anesthesia services
    - Arthrocentesis performed for the treatment of temporomandibular joint (jaw joint) dysfunction)
    - Diagnostic X-rays
    - Physical therapy (see Page 66 for physical therapy services)
    - Reversible appliance therapy (mandibular orthotic repositioning device such as a bite splint)

We do not pay for:

- Routine dental services
- Treatment that was previously paid as a result of an accident
- Dental implants and related services, including repair and maintenance of implants and surrounding tissue
- Dental conditions existing before an accident requiring emergency dental treatment
- Services to treat temporomandibular joint dysfunction (except as described above.)